

Quick Notes

Issue No. 5

June 24, 2004

IP Inpatient Discharges

ED Emergency Department

AS Ambulatory Surgery

This Issue of **Quick Notes** discusses the reporting of External Causes of Injury (E codes) to OSHPD. E codes are always a hot topic at Patient Data seminars and workshops. Accurate coding and comprehensive reporting make the statewide databases very valuable for a wide variety of public health benefits. Please review the changes in proposed regulations to E code reporting for Inpatient, Emergency Department, and Ambulatory Surgery records.

Procedures and observation services in ED and AS data are also discussed in this issue. Note the standard of using CPT procedure codes for outpatients rather than ICD-9-CM. This is a new classification system for patient data collection and we welcome your input and comments. Future plans include a new ED and AS reporting manual, as well as an updated Inpatient reporting manual.

IP ED AS

Reporting E Codes (External Cause of Injury)

In the official guidelines for coding external causes of injuries, poisonings, and adverse effects of drugs, *Coding Clinic for ICD-9-CM* summarizes the usefulness of E codes for classifying external causes of injury.

Injuries are a major cause of mortality, morbidity, and disability. In the United States, the care of patients who suffer intentional and unintentional injuries and poisonings contributes significantly to medical care costs. External causes of injury and poisoning codes (E codes) are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury happened (*cause*), the *intent* (unintentional, such as accident or intentional, such as suicide or assault), and the *place* where the event occurred. Some major categories of E codes include:

- Transport accidents
- Poisoning and adverse effects of drugs, medicinal substances and biologicals
- Accidental falls
- Accidents caused by fire and flames
- Accidents due to natural and environmental factors
- Late effects of accidents, assaults or self-injury
- Assaults or purposely-inflicted injury
- Suicide or self-inflicted injury

In July 1990, E code data was first collected on inpatient discharge data. California's requirements for E code reporting are found in Section 97227 of the California Code of Regulations. The purpose of this requirement is to help public health officials, legislators, and other data users target preventive strategies in minimizing the injuries, which in turn, reduce the morbidity, mortality, disability, and costs associated with injuries. An example of this would be the implementation of the helmet law for preventing head injuries incurred from motorcycle accidents.

For inpatient discharges, revisions are proposed to Section 97227 of the California Code of Regulations on External Cause of Injury. The revisions (in strikeout/underline format to show deletions/additions) are:

An E code is to be reported ~~only for the first inpatient hospitalization~~ on the record for the discharge during which the injury, poisoning, and/or adverse effect was first diagnosed and/or treated. Additional E codes shall be reported, if necessary, to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect ~~first diagnosed and/or treated during the current inpatient hospitalization~~.

Note: The reporting of E codes from ED and AS is no longer required only on the first "inpatient" record.

Reporting E Codes (Continued)

For Emergency Department and Ambulatory Surgery data reporting, new language is proposed in Sections 97260 and 97261 of the California Code of Regulations for both Principal External Cause of Injury and Other External Cause of Injury. Clarifying statements include: An E code is to be reported on the record for the encounter during which the injury, poisoning, and/or adverse effect was first diagnosed and/or treated. Additional E codes shall be reported, if necessary, to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

The regulatory changes are consistent with E coding guidelines in the *Coding Clinic for ICD-9-CM*, 4th Quarter 1995, pages 33-41 and 4th Quarter 1996, pages 72-79.

The coding guidelines are provided for entities that collect E codes so that there will be standardization in the process. Two key guidelines that apply to all settings including hospitals, outpatient clinics, emergency departments, other ambulatory care settings, and physician offices state:

- Assign the appropriate E code for all initial treatments of an injury, poisoning, or adverse effect of drugs;
- Use the full range of E codes to completely describe the cause, the intent, and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.

OSHPD allows the reporting of one Principal E code and four Other E codes.

The California Code of Regulations, Section 97227 for Inpatients and Section 97262 for ED and AS state, "If the principal E code does not include a description of the place of occurrence of the most severe injury or poisoning, an E code shall be reported to designate the place of occurrence, if available in the medical record." In coding the place of occurrence, the ICD-9-CM codes are E849.0-E849.9.

If the documentation is available in the medical record regarding where the principal event occurred, report the E code for place of occurrence. If the documentation is not available in the medical record regarding where the principal event occurred, report E849.9 for 'unspecified place'. It is true that one of Coding Clinic's suggested guidelines states, "Do not use E849.9 if the place of occurrence is not stated".

Reporting E Codes (Continued)

It is not clear when code E849.9 can be used. At this time, the state regulation overrides this particular suggested guideline for reporting Inpatient, ED and AS data to OSHPD.

Reporting Procedures

Principal and Other Procedures are data elements included in the Emergency Care Data Record and Ambulatory Surgery Data Record (specified by Sections 128736 and 128737 of the Health and Safety Code).

Each hospital and freestanding ambulatory surgery clinic shall submit an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed (Section 97213 of the California Code of Regulations). For purposes of reporting to OSHPD, a procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk (Section 97263 of the California Code of Regulations).

The Current Procedural Terminology, 4th Edition (CPT-4) is the standard medical code set for procedures in non-inpatient settings (Section 97213 of the California Code of Regulations). OSHPD allows for the reporting of one Principal Procedure and up to 20 Other Procedures. The full range of CPT codes, except those in Category II, should be used to report ambulatory surgery procedures performed. Modifiers are not required for reporting to OSHPD.

There are three categories within HCPCS' Level I CPT codes:

Category I CPT codes, established by the CPT Editorial Panel, are required for reporting services and procedures performed to OSHPD.

Category II CPT codes (0001F-0011F), as a set of supplemental tracking codes for performance measurement, are optional and not required for reporting to OSHPD.

Category III CPT codes (0001T-0074T), as a set of temporary codes for emerging technology, services, and procedures, are required to be used instead of Category I unlisted codes when reporting to OSHPD.

Reporting Procedures (Continued)

Procedure Questions and Answers:

Question: Should HCPCS' Level II G codes be reported, using the HCPCS codebook?

Answer: The Centers for Medicare and Medicaid (CMS) assign temporary G codes (G0001-G9999) to procedures and services, which are being reviewed prior to inclusion in the American Medical Association's CPT. Once CPT codes for these services and procedures are assigned, the G codes are removed from the HCPCS' Level II. Do not report G codes from Level II to OSHPD. Instead, report CPT codes from Level I to OSHPD.

Question: Should cancelled procedures be reported?

Answer: If a procedure is begun but cannot be completed, report the record to OSHPD with a procedure code showing the extent to which it was actually performed with the following principles: (1) if incision only, code to the incision of site, (2) if endoscopic approach is unable to reach site, code endoscopy only, (3) if cavity or space was entered, code to exploration of site, and (4) code one of the V codes (V64) as an Other Diagnosis to explain the reason for incomplete procedure. If a procedure is cancelled before the procedure began, do not report the record to OSHPD.

Question: Should invasive procedures performed in ancillary service sites be reported?

Answer: The physician gives the patient a requisition to obtain diagnostic and therapeutic services, such as x-rays, laboratory services, or physical therapy. In reference to required reporting in Section 97213 of the California Code of Regulations, an ambulatory surgery procedure is defined as one performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. This definition is also found in Section 128700 of Health and Safety Code.

If the ambulatory surgery procedure was performed in any one of these specified areas listed in the statutory and regulatory citations, then report the record to OSHPD.

Reporting Procedures (Continued)

If any ambulatory procedure, such as those done in other ancillary service sites, was not performed in any one of these specified areas listed in the statutory or regulatory citations, then do not report the record to OSHPD.

Please note that dates for Principal or Other Procedures are not required on the ED and AS data records.

How to Handle Observations following ED or AS Care

Include all observation services provided to the outpatient who was diagnosed and treated for emergency care and/or ambulatory surgery. An outpatient is defined as: (1) a person who has been registered or accepted for care but not formally admitted as an inpatient and who does not remain over 24 hours or (2) a patient at a freestanding ambulatory surgery clinic who has been registered and accepted for care as an outpatient (Section 97212 of the California Code of Regulations).

In *Coding Clinic for ICD-9-CM*, 1st Quarter 2003, pages 4-9, there are official coding instructions and examples regarding the observation status following the outpatient care in both ED and AS settings. For example, it states, "When a patient is seen for planned outpatient surgery at a hospital, code the reason for the surgery as the first reported diagnosis (reason for the encounter). Should the patient develop complications during the outpatient encounter, including those that arise during any observation stay, code these complications as secondary diagnoses. Continue to report the reason for the surgery as the reason for the overall encounter."



Quick Notes are mailed to MIRCal's primary contacts as informational bulletins on reporting requirements for Inpatient, Emergency Department and Ambulatory Surgery data.

Topics discussed in the previous issues were:

Issue No.1:

- The Law that governs these three data programs
- Confidentiality
- National Standards for ED and AS data reporting

Quick Notes (Continued)

Issue No. 2:

- Race and Ethnicity

Issue No. 3:

- Tips for reporting accurate ED and AS data. Included were condensed copies of the proposed web entry form, file layout, and minimum PC system requirements

Issue No. 4:

- Highlights of proposed ED and AS Title 22 Regulation changes

☀ **Future topics** will recognize OSHPD's partners, offer substantive information on additional data elements (Disposition, Social Security Number, and Expected Source of Payment), introduce new Computer-based Training, and explain Approval Criteria.

You are encouraged to **read and share Quick Notes**. It is currently the most downloaded item from the MIRCAl Informational Website.

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Next Issue:

"Our Partners" - Guest Articles